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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

CIGNA HEALTHCARE OF CONNECTICUT, INC.,

Petitioner,

v.

ROBERT S. NAPOLETANO, ET AL. and
F. BARRETT HOLLIS, ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF CONNECTICUT

BRIEF OF AMICUS CURIAE CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION IN SUPPORT OF CIGNA HEALTHCARE OF CONNECTICUT, INC.'S PETITION FOR WRIT OF CERTIORARI

LISSA J. PARIS
EVERETT E. NEWTON
(Counsel of Record)

MURTHA, CULLINA,
RICHTER and PINNEY
CityPlace I - 185 Asylum Street
Hartford, Connecticut
06103-3469
(860) 240-6000

Counsel for Amicus Curiae
Connecticut Business & Industry
Association

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INTEREST OF THE AMICUS CURIAE

The Connecticut Business & Industry Association ("CBIA") is the largest business and trade association in Connecticut, with approximately 10,000 members. Many CBIA members sponsor or administer ERISA employee health plans for their employees, and members include both in-state and multi-state employers. CBIA assists its members in identifying and choosing effective and cost efficient health care providers and employee benefit plan third-party administrators. CBIA and its members therefore absorb the direct impact of state laws that add to health plan administrative complexity and interfere with sound plan administration, as threatened by the state law claims of the *Hollis* and *Napoletano* plaintiffs.

CBIA submits this *amicus curiae* brief in support of CIGNA HealthCare of Connecticut, Inc.'s petition for a writ of certiorari, with the written consent of all parties, copies of which accompany this brief pursuant to S. Ct. R. 37.2(a).

REASONS FOR GRANTING THE WRIT OF CERTIORARI

Summary of Argument

The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, pre-empts the plaintiffs' state law causes of action because those actions seek to impose on plan administrators certain notice, reporting and contract compliance duties that conflict with ERISA's comprehensive disclosure scheme and because they seek to enforce plan provisions under a state law rubric that shadows the exclusive remedies provided by ERISA § 502, 29 U.S.C.

§ 1132. The posited state law duties would impose no mere theoretical, indirect or insubstantial administrative cost but a real, direct and substantial burden of complying with state statutory and common law requirements and answering in state court for any compliance lapse. Moreover, the very nature of the primary relief demanded -- reinstatement of physicians to a plan provider list -- strikes at the core structure of the ERISA plan and the ability of plan administrators to exercise efficient control over plan provisions.

Recognition of the plaintiffs' causes of action would open the floodgates nationwide to a tide of state regulation -- and private lawsuits -- seeking to "enforce" ERISA plan provisions. ERISA plan administrators would be forced to juggle the assertedly consistent but inevitably different provisions of ERISA and the laws of up to 50 states, including both statutory enactments and the common law. More significantly, they would be answerable to individual private complainants in state court under each state's interpretation of ERISA's requirements. The resulting administrative burden would stymie plan administrators in their efforts to control the costs of their plans and thereby threaten the very existence of employee health care plans. For these reasons CBIA writes to support the petition.

Argument

I. Allowing the Plaintiffs' Private State Law Claims Would Invite a Nationwide Patchwork of State Laws "Enforcing" Existing ERISA Plans.

The Connecticut Supreme Court has concluded that ERISA does not pre-empt the plaintiffs' private state law claims because the plaintiffs "do not attempt to prescribe the

substantive administrative aspects of a plan." Appendix to Petition for Writ of Certiorari ("App.") 33a. This theory of ERISA pre-emption would permit private state law enforcement actions so long as plaintiffs did not seek substantial revision of existing plan provisions. *See* App. 34a ("plaintiffs' claims merely turn on requiring CIGNA to enforce the benefit plan that it has already established and is maintaining"); App. 35a ("the *Napoletano* plaintiffs' claims simply assert that CIGNA has failed to enforce the employee benefit plan that it administers"). "Mere" enforcement of the plan as established, however, is the fundamental precept on which all of ERISA is built and is the key power that Congress has reserved to federal law and the federal courts. *E.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). ERISA does not pre-empt only those claims under state laws that are inconsistent with ERISA but all claims that "relate to" the plan. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). Thus, it is not enough that the plaintiffs' private state law claims would leave the CIGNA plan intact; the claims cannot be based on state law that "relates to" the plan.

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1683 (1995), this Court carved out an exception to ERISA pre-emption for state laws that impose only an indirect economic influence and do not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." The *Travelers* exception was applied where the state law served incidentally to make certain choices economically more attractive to administrators, but left the administrators free to "shop for the best deal." *Id.* at 1679. In effect, the type of indirect influence tolerated under *Travelers* is merely another market force acting on the health care delivery

system generally. *See, e.g., Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454, 456 (6th Cir. 1984) ("decisions [concerning benefits] are more appropriately influenced by forces in the marketplace and when appropriate, by federal legislation"), *cert. denied*, 469 U.S. 1109 (1985).

The rules of law created by the Connecticut Supreme Court are no mere market forces nor are they indirect or insubstantial in their intrusion on ERISA plan administration. The nine different state law private causes of action approved by the Connecticut court cut across state statutory and common law boundaries to permit plan participants and third-party service providers a mechanism, entirely separate from ERISA's comprehensive scheme, to enforce plan provisions. These nine state law provisions direct plan administrators to comply with plan provisions or face state law remedies, including injunctive relief demanded by private parties to restructure the plan to "original" specifications.

CBIA members who sponsor or administer plans for multi-state employee populations would be especially disadvantaged by Connecticut's spin on ERISA law. Instead of being subjected to the uniform federal regulation envisioned under ERISA, *see Ingersoll-Rand*, 498 U.S. at 142, multi-state plan administrators would be forced to view their administrative and fiduciary duties in light of the conflicting statutory and common law requirements of their multiple states, as well as the federal requirements. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 & n.25 (1983). It is not difficult to imagine, for instance, that physicians like Napoletano might be entitled to enforce third-party contract beneficiary rights under Connecticut law but not under the common law of Massachusetts or New York. Even the choice of applicable law for multi-state plans would present a legal morass. The

morass could only worsen as state legislatures throughout the country respond to the *Hollis* and *Napoletano* rulings by acting to "protect" their states' citizens from perceived inequities in ERISA plan administration and from the competing protective responses of their sister states.

It is no comfort to plan administrators that Connecticut requires "mere" plan compliance. Adequate notice, reporting, and contract compliance, as sought by the *Hollis* and *Napoletano* plaintiffs, exist not as abstract concepts but in the specific decisions of plan administrators. Administrators must decide whom to notify and how to do so, what to report to federal and state agencies, when to do so, and on what forms. They must decide whether excluding certain physicians comports with potentially conflicting requirements of the benefit plans and third-party contracts. These and myriad other decisions must be made, as efficiently and fairly as possible, for every plan participant and every contracted provider.

Before the *Hollis* and *Napoletano* decision, administrators in Connecticut looked only to federal law for guidance in making prudent decisions about notices, reports, and third-party contract compliance. After *Hollis* and *Napoletano*, administrators must also remain alert to state statutes and common law for additional "guidance" on the same subjects. Will the prudence and reasonableness of their actions be measured under ERISA rules in a federal court or by state rules in state court? This question must weigh heavily on administrators who bear personal liability for the prudence of their decisions. 29 U.S.C. §§ 1104, 1109. Administrators faced with the ambiguities inherent in the Connecticut Supreme Court's ruling must respond by taking excessive -- and therefore unnecessarily expensive -- precautions to satisfy

both federal and state requirements. This burden on plan administration is direct and substantial -- and untenable.

The Connecticut ruling presents more than a mere chilling effect on administrative decisionmaking; it sanctions a remedy that intrudes directly on the administrators' substantive choices of plan benefits by requiring that specific physicians be recognized as participating providers. For a plan that depends for its efficiency on its ability to limit the selection of providers, such an intrusion would be a virtual death knell. It is therefore essential that this fundamental ERISA issue be resolved by this Court and not, contrary to the intent of Congress, by state courts throughout the country applying their varying statutory and common law.

II. "Shadow" Enforcement of ERISA Plans Under State Law Would Drive Up the Cost of Plan Administration and Benefits.

CBIA and its members stand at the front line of a war on health care costs that has gripped this nation for 20 years or more[1]. ERISA encourages innovative efforts to control health care costs by relieving employee benefit plans of the burden of complying with state regulation. *E.g.*, *Travelers*, 115 S. Ct. at 1677; *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Vital to innovation in the control of costs is an ERISA plan administrator's freedom to exercise dis-

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1 Connecticut and other New England states have experienced some of the highest individual healthcare costs in the nation. Katharine R. Levit, *et al.*, *Health Spending by State: New Estimates for Policy Making*, Health Affairs, Fall 1993 at 7, 14, 15.

cretion in the design and implementation of a plan. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) (pension plan details subject to discretion of plan designers). ERISA pre-emption is therefore appropriately aimed at state regulation that would interfere with plan administrators' exercise of discretion in pursuit of such urgently needed plan efficiencies. The patchwork of state statutory and common law requirements approved by the Connecticut Supreme Court in *Hollis* and *Napoletano* presents just the sort of regulatory interference that is targeted by ERISA's pre-emption provisions.

The freedom to innovate in response to rapid changes in the health care field is fundamental to ERISA plan design and administration. *See Alessi*, 451 U.S. at 525. Congress expressly invested employee welfare plans, including health care plans, with broad discretion to adapt to changing circumstances. *See* 29 U.S.C. § 1051(1) (exempting welfare plans from participation and vesting requirements applicable to pension plans); 29 U.S.C. § 1081a(1) (exempting welfare plans from funding requirements applicable to pension plans). The courts have long noted the need for room to adapt to changes in health care. *See, e.g., Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988) "[M]edical insurance must take account of inflation, changes in medical practice and technology, and increases in the costs of treatment independent of inflation." ERISA leaves health care plan administrators a wide path to do just that.

The Connecticut Supreme Court's ruling frustrates Congress' intention to permit innovative adaptation within the federally created and supervised bounds of ERISA. The ruling does not merely provide an economic incentive to select one choice over another, *cf. Travelers*, 115 S. Ct. at 1683, but cuts off all choices that are not, in the unique view

of Connecticut state courts, legally and equitably consistent with existing plan provisions *and* with Connecticut's statutory and common law. The creation of a private cause of action for damages and injunctive relief belies any comparison with the permissible economic incentives outlined in *Travelers*.

One of the primary innovations in the delivery of health care services has been selectively contracted provider networks like CIGNA's. The dramatic increase of such managed care programs has contributed to a sustained reduction in the rate at which health care costs are growing nationwide. The medical care component of the consumer price index for 1996 increased by 3 percent, the smallest annual increase in 31 years according to the Bureau of Labor Statistics. (Bureau of National Affairs, Health Care Policy Report 117 (Jan. 20, 1997). This gratifying result followed a consistent trend through the 1990s: 9.6 percent in 1990; 7.9 percent in 1991; 6.6 percent in 1992; 5.4 percent in 1993; 4.9 percent in 1994; 3.9 percent in 1995. *Id.*

A provider network is most efficient when it includes an optimal number of highly skilled providers in each specialty to meet the needs of the subscriber population. It is by limiting the number and types of providers included in a network that an insurer is able to implement cost reductions in services for health beneficiaries. *See HCA Health Servs. of Virginia, Inc. v. Metropolitan Life Ins. Co.*, 752 F. Supp. 202, 204 (E.D. Va. 1990), *appeal dismissed*, 957 F.2d 120 (4th Cir. 1992). Providers benefit from guaranteed access to the large patient population; the plan benefits from its ability to negotiate lower health care delivery costs per capita or per provider. Interference with the selective relationship between plan and provider disrupts this balance and threatens to eliminate preferred provider networks as an economically viable option for plan administrators. *See Ball Memorial*

Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1343 (7th Cir. 1986) (Indiana's PPO statute held not to require admission of any willing provider because doing so would inhibit PPO's ability to negotiate cost-effective provider agreements). Permitting individual plaintiffs to demand damages and injunctive relief would transform this disruptive influence into a genuinely destructive force.

Finally, a plan's method of advising participants of plan provisions, such as the names of approved providers on a list that varies over time, is a key contributor to the administrative efficiency that can result from a properly managed health care delivery system. *See Fort Halifax Packing*, 482 U.S. at 9 (system efficiencies are "difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States"). Demands for specific notice and reporting of changes in the provider list, backed by threat of private suits for damages under state law, drastically increase administrative costs by requiring specific responses -- at the administrative level or in state court. This is not to suggest that employee benefit plans do not have important duties to communicate with their participants and comply with their own plan provisions, but the enforcement of those duties is a core ERISA concern that is exclusive to federal law and the federal courts. *Pilot Life*, 481 U.S. at 46; *Shaw*, 463 U.S. at 98-99.

In this case, the economic effects of the *Hollis* and *Napoletano* claims are neither indirect nor insubstantial. Rather, the Connecticut Supreme Court has ruled that individual plaintiffs may force CIGNA into a certain scheme of coverage by requiring adherence to plan requirements as interpreted by the state courts applying state law to measure adherence. If there is a distinction between forced "adoption" of a different scheme of coverage, as barred by

Travelers, 115 S. Ct. at 1683, and forced "adherence" to an existing scheme, as proposed by the Connecticut Supreme Court, that distinction must be explored under ERISA, not state law.

CONCLUSION

For the foregoing reasons, CBIA urges the Court to grant CIGNA HealthCare of Connecticut, Inc.'s petition for a writ of certiorari.

Respectfully submitted,

LISSA J. PARIS
EVERETT E. NEWTON
(Counsel of Record)

MURTHA, CULLINA, RICHTER and PINNEY
CityPlace I - 185 Asylum Street
Hartford, Connecticut 06103-3469
Telephone: (860) 240-6000

Attorneys for Amicus Curiae
CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION